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# Supreme Court of the United States

OCTOBER TERM, 1989

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C.; B.I. RADIOLOGY ASSOCIATES; BOOTH RADIOLOGY CONSULTANTS; CENTRAL GENERAL RADIOLOGISTS; COLUMBIA PRESBYTERIAN RADIOLOGISTS; CORNELL RADIOLOGY GROUP; DEMETER RADIOLOGICAL ASSOCIATES, P.C.; NATHAN GEFFEN, M.D., P.C.; GRAMERCY RADIOLOGY GROUP, P.C.; GREENE COUNTY RADIOLOGY CONSULTANTS, P.C.; H.S.S. RADIOLOGISTS; HAECOM RADIOLOGY

*(For Continuation of Caption See Inside of Cover)*

## PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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*Petitioners,*

—v.—

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

*Respondent.*

## QUESTIONS PRESENTED

1. Whether a monopolist may with impunity seek to preserve or enhance its monopoly, through threats of economic reprisals, in order to compel unwilling "sellers" to provide the services of unwilling third-parties, which services the monopolist does not normally buy and which the seller does not normally sell?

2. Whether such a monopolist may evade traditional bilateral negotiations with the "true sellers" of the desired services by coercing unwilling third parties, over whom it has monopoly power, to obtain the services for the monopolist on terms not otherwise available to it?

3. Whether in a "rule of reason" antitrust case, a district judge is free to choose between two sharply conflicting characterizations of a defendant's behavior, and, in the face of desposition testimony and "smoking gun" documents showing anti-competitive intent and coercive misconduct, grant summary judgment based upon the judge's decision to accept the benign alternative characterization advocated by the defendant?

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## Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

Petitioners respectfully request that a writ of certiorari issue to review the decision and judgment of the United States Court of Appeals for the Second Circuit, entered on September 14, 1989, affirming a decision of the Southern District of New York granting summary judgment in favor of respondent against petitioners' federal antitrust claims.

## OPINIONS BELOW

The opinion of the Court of Appeals, not officially reported at 884 F.2d 707, is reprinted at pages A-3 through A-4 of the appendix hereto.[1] The opinion of the District Court granting summary judgment to respondent is reported at 707 F. Supp. 708, and is reprinted at A-6 through A-23. An earlier opinion, by the district court judge to whom the case was originally assigned, and which sustained petitioners' position, is reported at 659 F. Supp. 132; it is reprinted at A-26 through A-36.

## JURISDICTION

The judgment of the Court of Appeals was entered on September 14, 1989. This Court has jurisdiction to review that judgment by writ of certiorari pursuant to 28 U.S.C. Section 1254(1).

## STATUTES INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. Section 1, provides in relevant part:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce . . . is declared to be illegal . . . .

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[1] A-____ denotes reference to the appendix hereto. JA __ denotes reference to the joint appendix filed in the Court of Appeals.

Section 2, 15 U.S.C. Section 2, provides in relevant part:

> Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize . . . shall be deemed guilty of a felony . . . .

## STATEMENT OF THE CASE

### I. Factual background:

#### a. Respondent monopolizes the Downstate hospital insurance market, but is relatively weak in the competitive market for medical insurance

Approximately 11 million people live in the 17 counties in the metropolitan New York City ("Downstate") area. Some 9 million of them, or over 80 per cent, have insurance against hospital bills under the Blue Cross plan offered by respondent Empire Blue Cross and Blue Shield, Inc. ("Empire"). (JA 543-51) In contrast, fewer than a third subscribe to Empire's Blue Shield insurance plan which covers physicians' bills. (JA 536.1-536.3)

This case arises out of a decision made in April 1984 by Empire to stomp out a perceived threat to its monopoly of the Downstate market for hospital insurance. At the same time, Empire determined to leverage its hospital insurance monopoly to shore up its relatively weak position in the far more competitive Downstate market for medical insurance.

#### b. Empire perceives that direct billing by self-employed hospital-based physicians threatens its positions in both markets

As reflected in its own board minutes, and as confirmed in deposition testimony from key Empire officials, the perceived threat to Empire's market share emerged from the fact that for several years one hospital-based medical specialist after another had converted from salaried employee status to that of self-employed private practitioner.

So long as hospital-based physicians functioned as salaried hospital employees, they did not send bills to patients. Instead, the cost of their professional services was included in hospital overhead and reimbursed by patients or their hospital insurers, including Empire's Blue Cross plan, directly to the Downstate Hospitals – in the same manner as are other elements of hospital overhead like the undifferentiated cost of facilities, supplies, administration, nursing, sanitation, etc.

Fundamental change came in the 1970s. The new federal Medicare program explicitly provided that, to the extent hospital-based physicians functioned as self-employed private practitioners rather than salaried employees, they were now able to bill Medicare patients directly for their professional services on a fee-for-service basis. In consequence, hospital-based medical specialists everywhere began converting to self-employed status – and for the first time began billing patients.

The Nation's anesthesiologists were the first to convert. When they began to direct bill patients, Blue Cross organizations everywhere, including Empire's Blue Cross plan, recognized this change in economic status and stopped reimbursing hospitals for the services of these now self-employed practitioners. In consequence, the anesthesiologists' professional services rendered to Blue Cross subscribers were no longer covered by Blue Cross, but by the patient's medical insurance – Blue Shield or one of its competitors.

The Nation's hospital-based radiologists[2] soon followed suit and themselves began converting to self-employed private-practitioner status. When this occurred, the same rule applied – the Blue Cross plans stopped reimbursing hospitals for the radiologists' services and, instead, coverage for these services switched to the

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[2] Radiologists are licensed physicians who have completed the required special training and residency to quality in that specialty. The *diagnostic* radiological services they render – their expert interpretations of radiological examinations (e.g., CT and MRI scans, sonograms, fluoroscopies and x-rays) – frequently constitute the primary and decisive medical basis for determining the course of a patient's care and treatment. Their *therapeutic* radiological services are used in the treatment and cure of many diseases, including cancer.

Blue Shield or other medical insurance plans — everywhere, that is, except in Downstate New York.[3]

At key April 1984 Empire board meetings, senior management concluded that the Blue Cross organizations in the other 49 states (and in the 45 New York counties outside the Downstate area) had erred in ever allowing these new private practitioners to direct bill patients. They concluded that they had themselves erred in allowing anesthesiologists to direct bill. And they concluded they would not repeat the "error" by permitting radiologists to do so.

Their motive was not (as assumed by the courts below) to promote cost-containment or any high-minded notion. Instead, it was pure economics. More precisely, their perception — as stated in the minutes of those board meetings — was that stripping away Blue Cross coverage for such hospital-based medical services would

> reduce the value of our product and imperil our market share. (JA 555)
>
> • • •
>
> The effect on our share of market, and the tendency toward further fragmentation of the system are additional serious problems inherent in this option. (JA 562)
>
> • • •
>
> The ultimate question comes down to whether we can continue to include these costs under the Blue Cross contract or abandon the field [of medical insurance] to others? (JA 555)

They reasoned that stripping away such coverage from their Blue Cross hospital insurance product would diminish its attractiveness. Moreover, because Blue Shield had only one-third as many subscribers as Blue Cross, two-thirds of this claims business would go to its competitors.

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[3] A 1987 study by the American College of Radiology, which filed an amicus brief in the Court of Appeals on behalf of petitioners, confirmed that no other insurance carrier in the country prohibits self-employed hospital-based radiologists from billing patients for their professional services.

c. Empire misuses its monopoly power to coerce the Hospitals, against their self-interest, into enforcing a concerted ban on direct billing

How, then, to prevent the logical consequence of the radiologists' converson to private practitioner status – direct billing of Blue Cross subscribers? As an insurer of hospital bills, Blue Cross deals with hospitals and their overhead, not physicians and their services to individual patients. And whereas its Blue Shield affiliate does regularly negotiate with physicians, it lacked the economic clout to dissuade the radiologists – who were already direct billing their Medicare, Medicaid, commercially insured, and all other private patients – from insisting on their right to direct bill those patients who happened to be Blue Cross subscribers.

The answer lay in Empire's enormous economic power over the Downstate Hospitals. Its 9 million Blue Cross subscribers generate $1 billion of annual revenues to the Hospitals. (JA 274) Dropping a hospital from the list of participating Blue Cross hospitals would be catastrophic. And given the Hospitals' precarious financial condition, informal delays in payment or slow responses to the administrative "appeals" which Hospitals file in reimbursement disputes would seriously impact hospital cash flow. In addition, Blue Cross as a matter of discretion makes loans or advances to assist hospitals with capital needs. (JA 714.50)

Moreover, respondent Empire wears a second hat. For most of the Downstate Hospitals, it serves as the local Medicare Part A Intermediary – meaning that it is "paymaster" for another $1.6 billion of annual hospital revenues. (JA 407-08) This puts respondent Empire in control of over one-half (and in some instances much more than that) of the Hospitals' total cash flow. (JA 407-08, 482)

At deposition, hospital administrators explained that the Hospitals' economic self-interest favored direct billing by hospital-based physicians, including radiologists. As one, with 20 years of experience in the Downstate area, testified:

> Number one, the hospitals no longer have to pay a salary to radiologists.

> Number two, the fee income derived by the radiologist is utilized not only to pay the radiologists but also to buy equipment for the radiology department, which the hospital might not have been able to afford without the fee-for-service revenue . . . .
>
> A third advantage to the hospital is the ability to attract and retain qualified physicians who are able to bill on a professional basis as do their peers, other physicians. (JA 430-31)

But the Hospitals were not free to act according to their will. On the contrary, they have been coerced by Empire to disregard their own self-interest and enforce Empire's ban on direct billing. They explained their fear to do otherwise in sworn deposition testimony. In the words of four hospital chief financial officers:

> [W]e have no choice . . . we are concerned about the revenge factor, that might take place from Blue Cross . . . . We certainly know that Blue Cross has the power to affect our revenues. (JA 476-82)
>
> • • •
>
> [I]f the hospital decided to do something differently, then there would be some potential problems with Blue Cross given their leverage on how much dollars they controlled which flowed into the institution. . . . [T]hat is to say, if you do allow the physicians to bill directly, the Hospital is in jeopardy of being cut off by Blue Cross. (JA 489)
>
> • • •
>
> It was basically a mandate from Blue Cross. (JA 493)
>
> • • •
>
> I don't think Richmond Memorial has had a choice of having an opinion in the matter. We've been told by a very powerful organization that this is the way life is, and we have chosen to just accept it. (JA 497)

The Hospitals' fears were well-founded. Senior Empire officials – the very individuals who control the lifeblood of the Hospitals' existence – blithely testified at deposition that if the Hospitals did not comply, they would invoke "sanctions," including terminating a Hospital as a Blue Cross participant, cutting off a Hospital's cash flow, or "anything else short of death." (JA 714.54)

Moreover, Hospital witnesses made clear that they did not join in enforcing the direct billing ban because of any provision in their 50 year-old agreements defining the contours of covered Blue Cross hospital services. On the contrary, as one experienced hospital chief financial officer testified regarding the applicable contractual language:

> I don't quite understand number three under paragraph number five, hospital care, "the benefits hereunder do not include services to the [subscriber's] attending physicians, surgeons, special nurses and their board. Separate arrangements must be made with the physician and surgeon for the payment of his fee for professional services."
>
> My interpretation of that [provision] in 1988 is that . . . the radiologists have every right to bill for their services. (JA 505)

Indeed, in 1943, these hospital agreements had been amended to clarify that "hospital services" specifically *excluded* "physicians and surgeons' fees." (JA 714.3)* And respondent Empire's largest subscriber contract, covering a million New York state employees and their families, provides:

> *Hospital Services Covered:* Blue Cross will usually pay for all of the diagnostic and therapeutic services provided by the hospital. *However, the service must be*

* Likewise, Empire's standard 120-day hospital subscriber contract provides that "hospital benefits . . . do not include services charged for by a private practitioner." (JA 714.20)

> *given by an employee of the hospital, the hospital must bill for the service, and the hospital must retain the money collected for the service.* (Emphasis added) (JA 714.6-714.12)

Anomalously, if a subscriber under this statewide agreement is hospitalized in the upstate Albany area, Empire recognizes that professional services by a self-employed hospital-based radiologist are not "hospital services" and are to be direct billed. If the same subscriber, pursuant to the same subscriber agreement, receives care at one of the Downstate Hospitals, direct billing is banned.

But Empire decided, in April 1984, to ignore these contracts and the objections of the Hospitals. Acting solely to preserve its monopoly of the hospital insurance market and to leverage that market power to avoid further impairment of its weaker share in the more competitive medical insurance market, Empire imposed its "billing ban" and coerced the Hospitals to enforce it — even though the Hospitals had ceased paying compensation to the radiologists and permitted direct billing for all other classes of patients. And it did so knowing full well that it would inflict damages of approximating $25 million annually upon the radiologists. (JA 535-36, 555)

**II. The proceedings below:**

Petitioners are some 60 groups of physicians practicing their medical specialty of radiology at the Downstate Hospitals. They comprise nearly 500 physicians — the majority of the hospital-based radiologists in the Downstate geographic area.

Like other self-employed private physicians, they direct bill their private, Medicare and Medicaid patients on a fee-for-service basis. But unlike their hospital-based peers in other medical specialties, including the anesthesiologists, they are banned from billing patients who happen to be Blue Cross subscribers. And that ban is enforced by the Hospitals, as a result of coersion by Empire.

In April of 1985, petitioners filed this suit in the Southern District of New York, alleging violations of Sections 1 and 2 of the Sherman Act. They charged that Empire conspires with the

Hospitals to tamper with the price mechanism for their radiological services, attempts to monopolize the hospital insurance market by suppressing their right to direct bill, and leverages its hospital insurance monopoly to shore up its weak Blue Shield affiliate in the medical insurance market.

Empire moved to dismiss, principally in reliance upon the First Circuit's decision in *Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). Empire argued that *Kartell* stands for the sweeping proposition that a buyer has an absolute right to determine what it wants to buy — in this case a bundle of hospital services which includes radiological services — and no antitrust issue arises when it finds a "willing" seller — here, the Hospitals.

**A. The original district judge rejects Empire's argument**

The federal district judge to whom this case was initially assigned rejected Empire's position in an opinion reported at 659 F. Supp. 132 (S.D.N.Y. 1987). (A-26 through A-36) The judge observed that a careful reading of *Kartell* disclosed no such right, for the First Circuit had confined its ruling to a purely bilateral situation between "legitimate" buyers and sellers of the services in question.[5] As the court put it,

> [I]f the insurance plan in *Kartell* had not dealt bilaterally with the physician-sellers of medical services but instead had acted as an inhibitory "third force" interfering in a separate buyer/seller relationship involving other persons, the relationship would not have been exempt from antitrust scrutiny.

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[5] The First Circuit had, after all, emphasized that "Here, Blue Shield and the doctors sit on opposite sides of the bargaining table.' " 749 F.2d at 929. And it had explained, at 924, that "To find an unlawful restraint, one would have to look at Blue Shield as if it were a third force,' intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains."

659 F. Supp. at 135-36. (A-32)[6]

**B. A newly assigned district judge accepts the same arguments her judicial predecessor had rejected, granting summary judgment in favor of respondent**

At the conclusion of over three years of discovery, Empire moved for summary judgment. At this point, the case was reassigned to a newly appointed district judge, the Hon. Kimba M. Wood. On February 24, 1989, the new judge abruptly granted summary judgment for Empire, accepting both the same legal grounds her judicial predecessor had rejected and Empire's characterization of the disputed facts.

Judge Wood read *Kartell* as standing for the expansive rule that a buyer — even one with unquestioned monopoly power — has an unfettered right to decide what combination of goods and services it wants to buy, and no antitrust objection can be made if it uses that monopoly power to coerce an unwilling "seller" to sell such a package. She rejected as without meaning Empire's anti-competitive motives, its monopoly power in the hospital insurance market, and its coercion of the Hospitals to join in enforcing the direct billing ban.

Empire's own admissions and the sworn testimony of its senior management and hospital officials abundantly supported the contrary conclusion that it had set out unlawfully to enhance its monopoly in one market and weak affiliate in a second, that it used its "hospital contracts" as a cover to impose terms contradicted by those same contracts, and that it embroiled the unwilling Hospitals in its scheme through coercive use of its monopoly power.

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[6] The court also rejected respondent's Section 2 standing argument, finding that petitioners' "injuries are the 'precisely intended' consequence of Empire's alleged antitrust violations and are 'inextricably intertwined' with the advantages sought against its competitors." 659 F. Supp. at 137 (A-35), citing *Crimpers Promotions, Inc. v. Home Box Office, Inc.*, 724 F.2d 290 (2nd Cir. 1983).

But Judge Wood chose to ignore or belittle these facts. Instead, she elected to characterize Empire as though it were the "legitimate buyer" postulated by *Kartell*, with the unfettered right to obtain its desired package of services from "willing sellers," the Downstate Hospitals.

### C. The Court of Appeals affirms

On September 14, 1989, the Court of Appeals for the Second Circuit affirmed on the opinion below. (A-3 to A-4)

## REASONS FOR GRANTING THE WRIT

With 9 million subscribers in a market of only 11 million people, and control of $1 billion in Blue Cross payments and another $1.6 billion in federal Medicare payments, Empire has enormous market power. Uncontroverted evidence shows that it uses that power to coerce the Downstate Hospitals, against their own self interest, to enforce the challenged "billing ban." And it does so for anti-competitive purposes and at the expense of the radiologists.

An increasingly sensitive issue in antitrust law today concerns the limitations, if any, upon the use and abuse of this kind of power. What restraints are there, if any, upon the sheer power of a monopolist or monopsonist to entrench itself or stomp out incipient threats to its position? Can such dominant forces insulate themselves from effective antitrust scrutiny behind some "unfettered right" of a "buyer" to choose with whom to do business, to decide what combination of goods and services it wants to buy and at what price, and to get its way by resort to coercion? And even if there are limitations, are they to be waived so long as the monopolist trots out the banner of alleged "cost containment" to paper over its admitted pursuit of still greater market share?

The decisions below liberate the dominant market force from the restraints which have been developed by this Court, expand the controversial *Kartell* decision and its progeny beyond the purely "bilateral" context in which they were decided, and substitute

a judge's pretrial factual conclusions as to how to characterize such behavior for the contrary conclusions a jury would have been entitled to reach.

## I. The decision below conflicts with and erodes this Court's decisions in *Aspen Skiing* and *Lorain Journal*, which impose essential limitations on misuse of market power

*Aspen Skiing Co. v. Aspen Highlands Skiing Corp.*, 472 U.S. 585 (1985), and *Lorain Journal Co. v. United States*, 342 U.S. 143 (1951), stand for the proposition that monopolists have no unfettered right like the one sanctioned by the decisions below. In both cases, dominant market forces set out to protect their market share. When challenged, they defended on the ground that all they had done was to make entirely lawful "unilateral" decisions about those with whom they would do business. This Court did not sustain such an unfettered right.

In *Aspen Skiing*, for example, the monopolist ski area was held to have violated Section 2 when it chose to discontinue participation in a ski-lift ticket program interchangeable in all four of Aspen's ski areas, with the intent and effect of improving its already dominant position *vis a vis* the smaller ski areas. And in *Lorain Journal*, the monopolist was found to have violated Section 2 when it simply and unilaterally refused to sell advertising to anyone who patronized a small nearby radio station which dared to compete.

In short, the pious truism articulated below that a "buyer" has an absolute right to define for itself what it wants to buy, what price it will pay, and how it will pursue its objectives has limitations – at least where, as here, monopoly power is involved. As the *Lorain* court said, in language quoted and reaffirmed in *Aspen Skiing:*

> The publisher claims a right as a private business concern to select its customers and to refuse to accept advertisements from whomever it pleases. We do not dispute that general right. "But the word 'right' is one

> of the most deceptive of pitfalls; it is so easy to slip from a qualified meaning in the premise to an unqualified one in the conclusion. Most rights are qualified. . . ." The right claimed by the publisher is neither absolute nor exempt from regulation. Its exercise as a purposeful means of monopolizing interstate commerce is prohibited by the Sherman Act.

472 U.S. at 601-02, quoting from 342 U.S. at 155.

The decisions below seriously erode these limitations. For they permit the monopolist's asserted "right" to evade antitrust scrutiny so long as it comes wrapped up in a "package" of goods and services the monopolist wants to "buy" and which it is able to coerce from an unwilling "seller" — even if the latter does not ordinarily "sell" what the monopolist insists on "buying."

Given the economic power of organizations like Empire, and the clout they exercise over the Nation's hard-pressed hospitals — and which the decisions below license them to extend to self-employed physicians — review is essential. Otherwise, the Downstate New York "exception" to the universal rule that self-employed physicians direct bill their own patients will surely spread to other jurisdictions — and one more area of economic freedom will drown in a sea of monopoly power. And restraints heretofore thought to limit the power of monopolists generally under decisions like *Lorain Journal* and *Aspen Skiing* will have been seriously eroded.

Because the courts below were beguiled by the notion of a "buyer's unfettered right," they disregarded the relevance of any particular limits on that power. One factor pushing them in that direction was Empire's *post hoc* rationalization about alleged "cost containment." But such reliance upon "cost containment" — a concern belied by Empire's contemporaneous anxiety about "imperil[ing] market share" — is foreclosed by this Court's landmark decision in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), invalidating a "maximum fee" schedule adopted by local medical societies. This Court found such medical services

industry "cost containment" a *per se* violation of the antitrust laws because it involved tampering with price. As the Court wrote:

> Any combination which tampers with price structures is engaged in an unlawful activity. . . . [T]o the extent that they raised, lowered, or stabilized prices they would be directly interfering with the free play of market forces. The [Sherman] Act places all such schemes beyond the pale and protects that vital part of our economy against any degree of interference. Congress has not left with us the determination of whether or not particular price-fixing schemes are wise or unwise, healthy or destructive.

457 U.S. at 346, quoting *United States v. Socony-Vacuum Oil Co.*, 310 U.S. 150, 221-22 (1940). Furthermore, this Court expressly rejected the suggestion that on "public policy" grounds health care and the medical profession should be exempted from the prohibition against tampering with price or price structure.

Review by this Court is required to prevent such use of the "cost containment" excuse to shield price-related misconduct by those possessing monopoly power.

**II. The decision below conflicts with the First Circuit's *Kartell* decision, and dangerously expands the license afforded purchasers with monopoly power**

Although Judge Wood purported to rely on the First Circuit's *Kartell* decision, she declined to recognize its self-expressed limitations. As affirmed, her decision is both in conflict with *Kartell* and expands it far beyond its intended scope. In consequence, it dangerously expands the license afforded those who would abuse monopoly power.

Judge Wood's judicial predecessor, Judge Shirley Wohl Kram, understood that when, at the outset of this litigation, she distinguished *Kartell* in denying respondent Empire's initial motion.

As she observed, 659 F. Supp. 132, at 135-36, *Kartell* involved a dispute between the two opposing sides to an actual agreement. Defendant Blue Shield[7] had routinely negotiated with the same groups of physicians who were now plaintiffs – and who were challenging agreements they had themselves reluctantly made with Blue Shield. After a full trial, the First Circuit concluded that it would hold the parties to their own bargain – and that *purely bilateral* negotiations between *legitimate* buyers and sellers over the terms under which the sellers would provide their own personal services do not give rise to antitrust claims.

The First Circuit had taken care to distinguish the situation where the arrangement at issue is not "bilateral" but involved intervention between buyer and seller by some outside "third force" nor normally party to their negotiations.[8] In that situation – which ours presents – the result would be entirely different. As Judge Breyer put it,

> To find an unlawful restraint, one would have to look at [defendant] as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.

749 F.2d at 924.

Judge Breyer's distinction between bilateral and trilateral conduct is consistent with basic antitrust doctrine. Judge Wood sought to brush off the difference by arguing that

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[7] Note that the defendant in *Kartell* was not hospital insurer Blue Cross, but Blue Shield – the medical insurer which pays physicians' bills, which routinely negotiates fee schedules with private physicians, and which had negotiated with them the agreements they challenged.

[8] Except for the decision below, *Kartell*'s numerous progeny honor this intrinsic limitation now discarded in the Second Circuit. See, e.g., *Barry v. Blue Cross of California*, 805 F.2d 866 (9th Cir. 1986); *Ball Memorial Hosp. v. Mutual Insurance*, 784 F.2d 1325 (7th Cir. 1986); and *Sausalito Pharmacy v. Blue Shield of California*, 544 F. Supp. 230 (N.D. Cal. 1981), *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016 (1982).

> Hence, if Blue Cross had chosen to purchase radiology services directly from the Radiologists, case law would clearly suport their right to do so and to ban balance billing to patients. (A-13)

But is it no defense to a Section 1 claim directed at concerted activity that the same result could be lawful had it been done unilaterally. In *United States v. General Motors Corp.*, 384 U.S. 127 (1966), the Government sued to stop General Motors from conspiring with dealers to terminate other dealers who provided cars to discounters. Defendant relied on the "location clause" in its dealer franchise agreement, contending that this clause would have entitled it to proceed on a unilateral basis. This Court rejected that argument, noting:

> Whatever General Motors might or might not lawfully have done to enforce [the agreement] is beside the point. And, because the action taken constitutes a combination or conspiracy, it is not necessary to consider what might be the legitimate interest of a dealer in securing compliance by others with the "location clause," or the lawfulness of action a dealer might individualy take to vindicate this interest.

384 U.S. at 140.

The decisions below, as affirmed by the Court of Appeals, write these careful and essential limitations out of *Kartell*. Contrary to *Kartell*, it is now the rule in the Second Circuit that it matters not whether the situation is bilateral or trilateral, whether plaintiff was himself party to the "bargain" he wishes to challenge, or whether the alleged "buyer" or "seller" are legitimately buyers and sellers of the goods or service at issue. Moreover, in the Second Circuit (and wherever else its expansion of *Kartell* may be followed) it matters not that the putative "buyer" abuses its market power to coerce a "sale" from an unwilling "seller."

Judicial condonation of this kind of license unleashes those most in need of restraint. Given the importance of this issue and its recurrent nature, this Court ought to eliminate the conflict and

clarify the rules governing abuse of market power in the guise of exercising one's "unfettered right" to "buy."

## III. The decision below departs from sound summary judgment practice, and in this respect also conflicts with and erodes *Aspen Skiing* and *Lorain Journal*

If anything is clear, it is that Judge Wood would never have permitted *Aspen Skiing* to go to the jury, for in her view she was entitled, on summary judgment, herself to determine how to "characterize" what defendant was doing.

Defendant's own formal board minutes, the deposition testimony of its own senior management, the uncontroverted deposition testimony of Downstate Hospital executives, and the inferences permissibly drawn from these materials would permit — if not compel — a fact-finder to accept petitioners' view of Empire's misconduct.

Although Judge Wood had an obligation, even after *Matsushita Electric Ind. Co. v. Zenith Radio Corp*, 475 U.S. 574 (1986), to accept the facts supporting petitioners' position and to draw all inferences in their favor, she did precisely the opposite. Setting aside or ignoring the well-developed facts about Empire's motive, intent, and coercive tactics,[9] she chose to decide for herself the ultimate fact issue — whether Empire was a "monopoly power" abuser like the *Aspen Skiing* and *Lorain Journal* defendants, or on the other hand, the benign innocent "buyer" coupled with a happily complaisant "seller" as postulated in *Kartell*.

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[9] The district court's reaction to the factual contentions raised on summary judgment is illustrated by her conclusion, at A-17, that weight should be given to the fact that "the Blue Cross purchasing system attacked here is supervised by state regulators." Yet she had before her the affidavit of the New York State Insurance Superintendent who swore that "Empire's decision to include the plaintiffs' services within its Blue Cross plan is not mandated by any state law, rule or regulation." (JA 634). And senior Empire officials had testified that they knew of no state law, rule or regulation requiring Empire to impose its ban on direct billing by the radiologists. (JA 527-28)

Such issues of "characterization," which inescapably involve questions of motive and intent, are not to be decided on summary judgment, except where all the facts favor the motion, or the opposition to the motion is "implausible." *Matsushita*, 475 U.S. at 593.[10] Indeed, if anything was "implausible," it was the "bilateral willing buyer and seller" scenario insisted upon by the district court despite all evidence to the contrary.

The teaching of *Poller v. Columbia Broadcasting System*, 368 U.S. 464 (1962), remains valid:

> [S]ummary procedures should be used sparingly in complex antitrust litigation where motive and intent play leading roles, the proof is largely in the hands of the alleged conspirators, and hostile witnesses thicken the plot.

368 U.S. at 473. This is especially so in "rule of reason" cases where, as pointed out in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978),

> competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed.

The facts developed after three years of discovery, if proven at trial, may have permitted a jury to reach the same conclusion as did Judge Wood regarding the proper characterization of Empire and its conduct. Surely, those same facts would even more easily have permitted the jury to place Empire in the same category as the *Aspen Skiing* and *Lorain Journal* defendants — as abusers of monopoly power. Or as an "intervening third force"

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[10] Another example of Judge Wood's failure to recognize the proper limits of her role is demonstrated by her bald conclusion that petitioners had offered no evidence to demonstrate any anti-competitive impact. (A-15) Her conclusion totally ignored affidavits from senior hospital officials who testified that certain of Empire's competitors sought to purchase the same package of services from the hospitals, but were refused since they lacked the market clout to induce the hospitals to disregard their own self-interest. (JA 1077-90).

within the meaning of *Kartell*. On summary judgment, the court had no right to choose between those conflicting sets of factual conclusions — and select the one sponsored by the party seeking summary judgment.

If district judges are free to disregard massive evidence of anti-competitive intent, and of the kind of "unduly coercive conduct" about which Judge Learned Hand warned in *United States v. Aluminum Company of America*, 148 F.2d 416, 429 (2nd Cir. 1945), and conjure up out of whole cloth the "benign, purely bilateral willing buyer and seller" scenario imagined below, then a gaping hole will have been cut in the federal laws regulating anti-competitive behavior.

## CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the decision and judgment of the Court of Appeals for the Second Circuit, as well as the underlying decision granting summary judgment in favor of Empire's coerced ban on direct billing.

December 12, 1989

Respectfully submitted,

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# APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE
SECOND CIRCUIT

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At a stated Term of the United States Court of Appeals for the Second Circuit, held at the United States Courthouse in the City of New York, on the fourteenth day of September one thousand nine hundred and eighty-nine.

Present: HON. WILFRED FEINBERG,
HON. JON O. NEWMAN, Circuit Judges.
HON. EDWARD DUMBAULD,
District Judge.*

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WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,

Plaintiffs-Appellants,

—against— Docket No. 89-7305

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Defendant-Appellee.

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Appeal from the United States District Court for the Southern District of New York

This cause came on to be heard on the transcript of record from the United States District Court for the Southern District of New York and was argued by counsel.

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* Honorable Edward Dumbauld, Senior United States District Judge for the Western District of Pennsylvania, sitting by designation.

ON CONSIDERATION WHEREOF, it is now hereby ordered, adjudged and decreed that the order of said District Court be and it hereby is affirmed in accordance with the opinion of this court with costs to be taxed against the appellants.

Elaine B. Goldsmith,
Clerk

/s/Edward J. Guardaro
by: Edward J. Guardaro,
Deputy Clerk

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,
Plaintiffs-Appellants,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC., Defendant-Appellee.

No. 1349, Docket 89-7305.

United States Court of Appeals,
Second Circuit.

Argued Aug. 31, 1989.

Decided Sept. 14, 1989.

Appeal from order of the United States District Court for the Southern District of New York, Kimba M. Wood, J., holding that the arrangements between defendant-appellee Empire Blue Cross and Blue Shield, Inc. and downstate New York hospitals, whereby inpatient radiological services are purchased as part of a package of hospital services, did not violate sections 1 and 2 of the Sherman Act. 15 U.S.C. §§ 1, 2.

Affirmed.

Daniel P. Levitt, New York City, Reid & Priest (Norton L. Travis, Garfunkel, Wild & Travis, P.C., of counsel), for plaintiffs-appellants.

Robert A. Bicks, New York City, Breed, Abbott & Morgan (Howard S. Wolfson, of counsel), for defendant-appellee.

Vedder, Price, Kaufman & Kammholz, Chicago, Ill. (Paul G. Gebhard, William C. Glynn, of counsel), for American College of Radiology, amicus curiae.

Before FEINBERG and NEWMAN, Circuit Judges, and DUMBAULD, District Judge.*

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* Honorable Edward Dumbauld, Senior United States District Judge for the Western District of Pennsylvania, sitting by designation.

PER CURIAM:

Plaintiffs-appellants, a majority of the hospital-based radiologists in 17 downstate counties in and around New York City, appeal from an order of the United States District Court for the Southern District of New York, Kimba M. Wood, J., granting the motion for summary judgment of defendant-appellee Empire Blue Cross and Blue Shield, Inc. ("Empire"). Appellants challenge the arrangements between Empire and the downstate hospitals, whereby inpatient radiological services are purchased as part of a package of hospital services, so that radiologists do not bill Blue Cross subscribers directly for their services. Appellants contend that Empire's arrangements with the hospitals violate section 1 of the Sherman Act, 15 U.S.C. § 1, by coercing the hospitals, through the use of monopoly power, to sell the services of appellants radiologists on terms that Empire could not obtain through legitimate bilateral negotiations with appellants. Appellants further contend that Blue Cross insists on so purchasing inpatient radiological services in order to use its leverage in the hospital insurance market to gain a competitive advantage in the medical services insurance market in contravention of section 2 of the Sherman Act. 15 U.S.C. § 2. Appellants finally argue that the court below should not have granted summary judgment because there were issues of fact for a jury.

We affirm for the reasons stated in Judge Wood's well-reasoned opinion, reported at 707 F.Supp. 708.

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WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., ET AL.,

Plaintiffs,

— against —

EMPIRE BLUE CROSS AND BLUE SHIELD, INC.,

Defendant.

: 85 CIVIL 2733 KMW

: JUDGMENT

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Defendant having moved for summary judgment and the plaintiffs having cross-moved for partial summary judgment to strike the McCarran-Ferguson and state action defenses, and the said motions having come before the Honorable Kimba M. Wood, U.S.D.J. and the Court thereafter on February 27, 1989, having handed down its opinion and order (#63857), granting defendant's motion for summary judgment and dismissing this action with prejudice, it is,

ORDERED, ADJUDGED AND DECREED: That this action be and it is hereby dismissed with prejudice.

DATED: NEW YORK, N.Y.
February 28, 1989

/s/Raymond F. Burghardt
Clerk

THIS DOCUMENT WAS ENTERED ON THE DOCKET ON 3-1-89.

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al.,
Plaintiffs,

v.

EMPIRE BLUE CROSS AND BLUE
SHIELD, INC. Defendant.

No. 85 CIV. 2733 (KMW).

United States District Court,
S.D. New York.

February 24, 1989.

Hospital-based radiologists brought action against health insurer alleging unlawful restraint of trade, monopolization and price fixing in violation of federal antitrust laws on ground that insurer insisted that hospitals that contracted to offer radiological services to insurer's subscribers do so at a certain price as part of a package of such services. On defendant's motion for summary judgment, the District Court, Kimba M. Wood, J., held that: (1) health insurer's agreement with hospitals did not constitute illegal price fixing, as there was no evidence of any injury to competition flowing from agreement, and (2) even assuming that insurer used its market power to obtain favorable prices from hospitals for provision of radiological services, antitrust laws did not prevent buyer with market power from negotiating good price or specifying what it will buy when there was no evidence of injury to insurer's competitors.

Motion granted.

## OPINION AND ORDER

KIMBA M. WOOD, District Judge.

Plaintiffs allege unlawful restraint of trade, monopolization, and price fixing in violation of the federal antitrust laws and New York State law. 15 U.S.C. §§ 1, 2; N.Y.Gen.Bus.Corp.Law § 340. Plaintiffs seek treble damages and injunctive relief. The case is presently before the Court on defendant's motion for summary judgment on the grounds that (1) defendant's alleged conduct does not violate Sections 1 and 2 of the Sherman Act; (2) plaintiffs' claims are barred by the McCarran-Ferguson Act; and (3) plaintiffs' claims are barred by the state action doctrine. Plaintiffs cross-move for partial summary judgment to strike the McCarran-Ferguson and state action defenses.

In proceedings before the judge to whom this action was originally assigned, defendant moved to dismiss the complaint. Although the Court believes that defendant's prior motion should have been granted, the Court has considered all the affidavits, exhibits, and legal memoranda submitted by the parties. After a thorough review of the record, the Court finds that there is no genuine issue as to any material fact and that defendant is entitled to judgment as a matter of law. Accordingly, defendant's motion is hereby granted and plaintifffs' cross-motion is denied.

### *FACTS*

The key facts are not in dispute. Plaintiffs are a majority of the hospital-based radiologists (the "Radiologists") who work in the 17 counties in and around New York City ("Downstate New York").[1] Defendant Empire Blue Cross and Blue Shield, Inc.

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[1] Radiologists are licensed physicians who have completed special residency programs in radiology and have thereby become qualified in that particular medical specialty. The Second Amended Complaint defines radiology as "the medical specialty concerned with the diagnostic and therapeutic use of X-rays, radium rays and other forms of radiant energy or its equivalent, in the diagnosis and treatment of disease or injury." Second Amended Complaint, ¶ 5. The radiology services that plaintiffs seek to exclude from coverage in Blue Cross' hospital coverage contracts are non-interventional (*i.e.*, non-surgical) inpatient diagnostic and therapeutic radiological services. For ease of reference, these will be referred to simply as "radiology services."

("Empire") is a non-profit health insurance corporation organized and existing under Article 43 of the New York Insurance Law. Empire is the product of a merger of Blue Cross/Blue Shield of Greater New York, Inc., which served Downstate New York, and Blue Cross of Northeastern New York, Inc., which served the Northeastern New York area.

Empire offers two basic insurance plans: "Blue Cross," which covers certain defined hospital services and benefits, and "Blue Shield," which covers certain professional medical services provided by physicians. An individual or group may purchase one plan without purchasing the other; that is, one may purchase both Blue Cross coverage and Blue Shield coverage, Blue Cross coverage without Blue Shield coverage or Blue Shield coverage without Blue Cross coverage. Empire provides Blue Cross hospital service benefit coverage to more than 9 million covered persons. Some of these individuals buy partial hospital benefit coverage from Blue Cross, and supplemental hospital benefit coverage from others.

In order to provide inpatient hospital services pursuant to these subscriber contracts, Blue Cross entered into contracts with hospitals whereby the hospitals accept payments from Blue Cross as full reimbursement for covered services rendered to Blue Cross subscribers (*i.e.*, the hospitals may not seek to collect additional charges from Blue Cross' subscribers). Since Blue Cross' founding over 50 years ago, the Downstate New York hospitals have provided technical (and, as they developed, professional) radiology services to Blue Cross subscribers as covered hospital services. See Defendant's Rule 3(g) Statement, ¶ 7; Supplement to Plaintiffs' Rule 3(g) Statement, ¶ 7.

Radiology services were usually provided by hospital employees until the 1970's. In the 1970's, as radiology developed as a specialty, many radiologists chose to become independent contractors to hospitals rather than to be hospital employees, although they continued to practice on the hospital premises. At the same time, the Radiologists began to seek to bill Blue Cross subscribers directly on a fee for service basis rather than to bill the hospitals, which in turn bill Blue Cross. In most areas

Blue Cross has acquiesced, and no longer requires hospitals to offer radiology services as part of a package of hospital services. In those areas, Radiologists either bill patients directly or bill their medical insurance plans.

In the 17 downstate counties in New York, however, Blue Cross insists that hospitals that contract with Blue Cross continue to offer radiology services to Blue Cross subscribers as part of a package of hospital services. The Radiologists claim that this practice has the effect of "unnaturally" limiting how much they can charge for their services. That is, they could charge patients more if they could bill patients directly, by-passing both hospitals (whose charges are closely monitored by a number of regulatory agencies, state and federal) and Blue Cross (whose purchasing power permits it to drive a hard bargain).[2] The Radiologists also point out that they feel demeaned by their inability to bill in the same manner permitted to other physicians. Second Amended Complaint, ¶ 29. Recognizing, as they must, that the antitrust laws provide no remedy either for being professionally demeaned or for not being able to charge as much as one would like, the Radiologists attempt to bring their claim within the ambit of the antitrust laws in two ways.

First, the Radiologists claim that the agreement between Blue Cross and each hospital results in price fixing which unreasonably restrains trade, in violation of Section 1 of the Sherman Act, 15 U.S.C. § 1. Second, they claim that Blue Cross' ability to extract favorable terms from hospitals results from Blue Cross' enormous purchasing power, and that Blue Cross is (1) using its purchasing power to monopolize the hospital service and benefit insurance market, and (2) leveraging its power in the hospital service and benefit insurance market to give a competitive advantage to its affiliate, Blue Shield, in the medical service market – all to the alleged detriment of other insurers and health maintenance organizations, all in violation of Section 2 of the Sherman Act, 15 U.S.C. § 2.

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[2] According to Radiologists, they could bill $25 million more per year in Downstate New York if they could bill patients directly.

## DISCUSSION

*1. Sherman Act § 1*

[1] Recent Supreme Court decisions suggest that a court should begin its antitrust analysis with a threshold examination of an alleged restraint.[3] If the alleged restraint appears clearly anticompetitive, a court should find the restraint to be *per se* unlawful; if the alleged restraint may be necessary to achieve a pro-competitive result, a court should test the restraint by the rule of reason. The restraint here is not clearly anticompetitive, and may be necessary to achieve a pro-competitive result. Blue Cross produces lower prices for consumers by using its bargaining power to purchase radiology services as part of a bundle of hospital services. The challenged agreements are ancillary to Blue Cross' attempt to design efficient insurance coverage for subscribers, and may counter what has been characterized by several commentators as a historical insensitivity of physician prices to competition. *See* "Joint Provider Activities Affecting Price," ABA Antitrust Section Draft Working Paper 4-10, 73-75 (1989); Note, *Prepaid Prescription Drug Plans Under Antitrust Scrutiny: A Stern Challenge to Health Care Cost Containment*, 75 Nw.U.L.Rev. 506, 518 n. 69, 524-525; D.W. Kallstrom, *Health Care Cost Control by Third Party Payors: Fee Schedules and the Sherman Act*, 1978 Duke L.J. 645, 647-649 (1978); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross and Blue Shield of Connecticut, Inc.*, 675 F.2d 502, 506 (2d Cir.1982) (reference to "the normal insensitivity of drug prices"). The agreements permit a sophisticated buyer, Blue Cross, to monitor and predict charges, and permit it to offer cost containment as a service to its less sophisticated, individual subscribers.[4] *See Prepaid*

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[3] *NCAA v. Board of Regents*, 468 U.S. 85, 107, 104 S.Ct. 2948, 2963, 82 L.Ed.2d 70 (1984); *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982); *Broadcast Music Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 99 S.Ct. 1551, 60 L.Ed. 2d 1 (1979); 7 P. Areeda, Antitrust Law ¶ 1511, at 431 (1986).

[4] Kallstrom wrote, eleven years ago:
Given the chance to run their natural courses, market incentives should draw insurance companies into the business of offering cost containment as a

*(Footnote continued)*

*Prescription Drug Plans*, *supra*, at 524; *Kallstrom*, *supra*, at 649. In 1982 the Second Circuit held that similar conduct was properly analyzed under the rule of reason. The Court held that in determining whether a restraint is unreasonable, a court must analyze

> whether, under all of the circumstances of the case, including the facts peculiar to the business and the history of, reasons for, and market impact of the restraint, the restrictive practice imposes an unreasonable restraint on competition.

*Medical Arts*, 675 F.2d at 504.

The Radiologists claim that the agreements between hospitals and Blue Cross restrain competition in violation of Sherman Act Section 1 by preventing the Radiologists from billing directly patients who are Blue Cross subscribers.[5] This claim is similar to ones asserted over the past fifteen years by other providers of goods and services to insurers. Health care providers, in particular, dismayed by the diminution of their market power vis-a-vis buyers representing large numbers of patients, have recently attempted numerous antitrust attacks upon insurers. Courts have consistently rejected, in the health insurance context, the argument advanced in many of these attacks that the antitrust laws

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service to health care consumers. That insurance companies have not already undertaken to provide this service indicates that market forces have not been permitted to operate freely. At every turn in the road to cost-control innovation insurers have been faced with barriers, often in the form of restrictive practices of organized medicine or of legislation created at the behest of the medical establishment. [Footnote omitted.] *Kallstrom*, *supra*, at 649.

[5] Two other arguments made by the Radiologists in connection with their Section 1 claim have no basis in antitrust, and a third will be assumed by the Court to be correct for purposes of this motion. The argument that Blue Cross and hospitals "are not legitimately concerned with physicians' fees" has no basis in antitrust, unless it is an attack on Blue Cross' ban on direct billing, dealt with *infra*, pp. 711-13. Similarly, there is no antitrust basis for the argument that it is unreasonable for Blue Cross to buy radiology services from hospitals, given that Blue Cross chooses to buy no other physicians' services

*(Footnote continued)*

give providers of goods and services a right to bill directly patients who are Blue Cross or Blue Shield subscribers. Doctors and pharmacies, among others, have sued health insurers for refusing to let them bill patients directly amounts *in addition* to those the doctors and pharmacies receive from the insurers. Courts have consistently held that this "ban on balance billing" does not unreasonably restrain trade; the only restraint is the one that flows inevitably and properly from the choice by the insurer to buy services and products of a particular type from doctors and pharmacies, *i.e.*, fully-paid services and products.[6] *Medical Arts*, 675 F.2d 502 (Blue Shield may require pharmacies to accept Blue Shield payments as full reimbursement for drugs sold to Blue Shield subscribers); *Kartell v. Blue Cross of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir.1984)(Blue Shield may

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from hospitals; nothing in the antitrust laws requires buyers to be consistent. The Radiologists also argue that it is contrary the hospitals' self interest to sell radiology services, given the additional administrative burden that entails; this argument is presumably made in support of the Radiologists' contention that Blue Cross has market power. The Court accepts as true, for purposes of this decision, the contention that Blue Cross has market power. *See* pp. 714-15 *infra*.

[6] It is difficult to tell from the Radiologists' submissions to the Court whether the Radiologists argue that Blue Cross should not be characterized as a "buyer" because it buys on behalf of subscribers. That argument would be unavailing. For antitrust purposes, Blue Cross is treated as a buyer where it pays the bill and seeks to set the amount to be charged. *See Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 216, 217, 99 S.Ct. 1067, 1075-1076, 59 L.Ed.2d 261 (1979); *Medical Arts*, 675 F.2d at 505; *Kartell, et. al. v. Blue Shield of Massachusetts, Inc., et al.*, 749 F.2d 922, 925, 928 (1st Cir.1984), *cert. denied* 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985); *Brillhart v. Mutual Medical Ins. Inc.*, 768 F.2d 196, 199 (7th Cir. 1985); *Michigan State Podiatry Ass'n v. Blue Cross and Blue Shield of Michigan*, 671 F.Supp. 1139, 1152 (E.D.Mich.1987); *Mortensen v. First Federal Savings and Loan Ass'n*, 1975-2 Trade Cas. (CCH) ¶ 60,570 at 67,501 (D.N.J.1975), [1975 WL 972]; *Sausalito Pharmacy, Inc. v. Blue Shield of California*, 544 F.Supp. 230, 233, 238 (N.D.Cal.1981), *aff'd.* 677 F.2d 47 (9th Cir.1982), *cert. denied*, 459 U.S. 1016, 103 S.Ct. 376, 74 L.Ed.2d 510 (1982); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 784 F.2d 1325 (7th Cir.1986); *Pennsylvania Dental Assoc. v. Medical Service Assoc.*, 815 F.2d 270 (3d Cir.), *cert. denied*, __U.S.__, 108 S.Ct. 153, 98 L.Ed.2d 109 (1987); *Blue Cross and Blue Shield of Michigan v. Michigan Assoc. of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich.1980)[1980 WL 1848].

require doctors to accept Blue Shield payments as full reimbursement for services sold to Blue Shield subscribers; *i.e.*, Blue Shield may ban balance billing); *Travelers Insurance Co. v. Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093, 94 S.Ct. 724, 38 L.Ed.2d 550 (1973)(Blue Cross may require hospitals to accept Blue Cross payments as full reimbursement for services rendered to Blue Cross subscribers); *see Quality Auto Body, Inc. v. Allstate Insurance Co.*, 660 F.2d 1195 (7th Cir.1981), *cert. denied*, 455 U.S. 1020, 102 S.Ct. 1717, 72 L.Ed.2d 138 (1982)(auto insurers may require repair shops to accept payment at the "prevailing competitive rate" as full reimbursement for their services). Hence, if Blue Cross had chosen to purchase radiology services directly from the Radiologists, case law would clearly support their right to do so and to ban balance billing to patients.

The only distinctions between the above-cited cases and the instant case are distinctions with no antitrust significance. First, the Radiologists seek to bill patients for their entire fee, rather than the balance over the amount paid by an insurer. The decisions cited above, however, stand for the proposition that the antitrust laws do not prohibit a buyer either from buying for the account of others, or from specifying that the services it buys be fully-paid services. The Radiologists do not have to serve Blue Cross subscribers; if they do so, however, they must accept the payment in conditions specified by Blue Cross, that is, all payments must come from Blue Cross, not from the subscribers.

Second, here there is one more intermediary interposed between the physician and the patient, *i.e.*, the hospital.[7] It is difficult to see why this fact should have any antitrust significance. The Radiologists' argument is as follows: Blue Cross insists that hospitals sell it fully paid hospital services, including radiology

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[7] The only detriment to the Radiologists that is added by the hospital being an intermediary between the Radiologists and Blue Cross is that hospital costs are subject to governmental regulation that may have the effect of containing costs. *See* Affidavit of James Corcoran, Esq., New York State Superintendent of Insurance, July 12, 1988 (hereinafter "Corcoran Aff."), ¶ 31. This fact has no bearing on the analysis above.

services; to effect the sale, hospitals must, in their agreements with the Radiologists, forbid the Radiologists to bill patients directly for services sold to Blue Cross through the hospitals; Blue Cross has thereby intervened as a "third force" in the relationship between the hospitals and the Radiologists; the First Circuit's recent *Kartell* decision states (in *dictum*) that it would be unlawful for a "third force" to "prevent willing buyers and sellers from independently coming together to strike price/quality bargains." *Kartell*, 749 F.2d at 924.[8] Although *Kartell* contains what this Court reads as a jocular reference to a sinister "third force,"[9] there is no authority whatever for the proposition that a seller has an *antitrust* remedy where a buyer insists upon buying his services through an intermediary. This is not a case where Blue Cross is preventing willing buyers and sellers from independently striking bargains – the Radiologists and the hospitals are free to strike any bargains they wish with one another. But if they wish to sell to Blue Cross, they must sell

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[8] Blue Cross raised this argument previously in its motion to dismiss. At that time, the judge to whom the case was then assigned denied the motion to dismiss, holding that the contracts between Blue Cross and the hospitals in this case are epxressly excluded from the holding in *Kartell* because Blue Cross was alleged to be a "third force" intervening in the relationship between the Radiologists and the hospitals. *Westchester Radiological Assoc., P.C. v Empire Blue Cross and Blue Shield, Inc.*, 659 F.Supp. 132 (S.D.N.Y.1987). For the reasons stated in this opinion, I believe that decision was erroneous and contrary to well-established antitrust precedent.

The Radiologists argue that the earlier decision constitutes law of the case and should not be disturbed. However, the law of the case doctrine "merely expresses the practice of courts generally to refuse to reopen what has been decided, not a limit to their power." *Messinger v. Anderson*, 225 U.S. 436, 444, 32 S.Ct. 739, 740, 56 L.Ed. 1152 (1912) (Holmes, J.). Furthermore, denial of a motion for summary judgment does not preclude the grant of summary judgment by another judge. *Wright v. Cayan*, 817 F.2d 999, 1002 n. 3 (2d Cir.1987), *cert. denied*, __U.S.__, 108 S.Ct. 157, 98 L.Ed.2d 112 (1987); *Dictograph Products Co. v. Sonotone Corp.*, 230 F.2d 131, 134-136 (2d Cir. 1956)(Hand, J.); Wright, Miller & Cooper, Federal Practice and Procedure § 4478 (1981).

[9] Counsel for the Radiologists are unaware of any case holding that an insurer acted as a "third force" under *Kartell*. Transcript of Oral Argument, January 5, 1989 (hereinafter "Tr.") at 24-25.

Blue Cross the package it wants to buy, and they must agree that the price charged to Blue Cross will be the only charge for the services.

Furthermore, the Radiologists have produced no evidence of any injury to competition flowing from this agreement. When questioned at oral argument, the Radiologists' counsel stated that "[t]he injury to competition is the competition between the defendant and its hospital insurance competitors, and Blue Shield and its medical insurance competitors." Tr. at 3-4. However, at oral argument the Radiologists' counsel admitted that the Radiologists have (1) no evidence that Blue Cross has done anything to prevent its competitors from negotiating with hospitals to buy the same bundle of services that Blue Cross buys (Tr. at 8),[10] (2) no evidence that Blue Cross has attempted to control agreements between the hospitals and other insurers (Tr. at 9-10), (3) no evidence that Blue Cross interferes in any way with the relationship between the radiologists and patients who are not covered by Blue Cross (Tr. at 10-12),[11] and (4) no evidence that Blue Cross direclty tells, or even suggests to, the hospitals

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[10] The Radiologists cited no evidence in their papers or at oral argument that any of Blue Cross' competitors asked to buy from any hospital the same bundle of services that Blue Cross buys. (Tr. at 6-7). Subsequent to oral argument, the Radiologists submitted the affidavits of a vice president at each of two hospitals (Affidavit of James Pierce, January 23, 1989; Affidavit of Sylvia Hotlzberg, January 24, 1989). James Pierce attests that three health organizations sought the same terms as Blue Cross, and his hospital refused. Sylvia Holtzberg attests that one organization asked her hospital to include the services of hospital-based physicians within the services provided to subscribers, and was refused. Neither affidavit explains why the hospitals refused, and neither affidavit claims that Blue Cross was in any way involved in the hospitals' decision.

[11] The Radiologists concede that when a hospital-based radiologist treats a patient who is *not* a Blue Cross subscriber, Blue Cross' contracts with the hospitals have *no impact* on the radiologist's ability to direct-bill that patient. Plaintiffs' Memorandum of Law in Opposition, p. 12. It is only when a hospital-based radiologist provides services to a Blue Cross subscriber that the radiologist is forbidden to direct-bill patients.

what to pay radiologists (Tr. at 12-13).[12] The Radiologists' sole contention is that because of Blue Cross' market power, Blue Cross is able to get better terms for its subscribers than are other insurers. This is insufficient to make out a Section 1 claim. Blue Cross is simply acting as a rational buyer attempting to get the best possible terms for its subscribers.[13]

Finally, as in the *Kartell* case, there are additional circumstances here that favor applying traditional antitrust principles, rather than stretching to create new causes of action.

First, the Blue Cross system under attack here promotes cost containment in an area in which the government has recognized the need for cost containment. There has been a growing governmental realization that traditional ways of paying for health care provided little or no incentive for efficiency and were inherently inflationary. According to the United States Department of Health, Eductation and Welfare, "[p]robably the principal factor contributing to inflation has been the predominant system of third party reimbursement based on what institutions spend and what physicians charge."[14] Recognizing the need for government action to promote cost containment, legislatures,

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[12] Furthermore, although Blue Cross makes the decision to include or exclude radiology services in its Blue Cross coverage, the evidence is clear that Blue Cross does not unilaterally fix the price of the hospital services as the Radiologists claim; New York State sets the price. See pp. 714-15 *infra*.

[13] *See, Brillhart*, 768 F.2d at 201:

> The antitrust laws do not prohibit a buyer from bargaining for the best deal possible. As the district court noted, the conduct by Blue Shield in the present case is not the type of conduct that the antitrust laws were intended to prohibit. This conclusion is especially true where there is no suggestion that Blue Shield ever conspired with any other health care insurer to set prices, where nonparticipating doctors remain free to charge their patients whatever price that they choose, and where participating doctors remain free to charge non-Blue Shield subscribers whatever price they choose. In sum, the provider agreement in this case does not violate the antitrust laws.

[14] United States Department of Health, Education and Welfare, Forward Plan for Health: Fiscal Years 1978-82, at 34 (1976).

including Congress and the New York State legislature, have adopted prospective payment systems for hospitals. Pursuant to these systems, the appropriate amount of reimbursement to a hospital for certain patient care is determined *before* the care is rendered, giving hospitals a strong incentive to contain costs. Similarly, the executive branch has recognized the need for cost containment in the health care field. In 1982, the Department of Justice Antitrust Division gave a favorable Business Review Letter to 160 not-for-profit hospitals (which represented 80% of all such hospitals in Ohio) who wanted to increase their market power by banding together to purchase hospital products jointly. The Department of Justice noted with approval that this joint buying scheme might enable the group to obtain lower prices, resulting in further cost containment by hospitals.[15]

Second, the Blue Cross purchasing system attacked here is supervised by state regulators. Although that supervision may or may not rise to the level needed to invoke the state action exception to the antitrust laws,[16] there is no dispute that New York State sets the reimbursement rate that Blue Cross may pay to hopitals for patient care:

> Blue Cross rate setting methodology is required by law to be consistent with the Medicaid rate setting methodology prescribed by the state. This means that Blue Cross can pay hospitals neither more nor less than the rate established by state law, as determined by the [New York State] Department [of Health].

Affidavit of Raymond Sweeney, Director of the Office of Health Systems Management of the New York State Department of Health, July 11, 1988 (hereinafter "Sweeney Aff."), ¶14. In

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[15] Justice Department Business Review Letter from William F. Baxter, Assistant Attorney General, Antitrust Division, to B. William Dunlap, Ohio Hospital Association (June 9, 1982).

[16] Because I hold that the alleged conduct does not violate the antitrust laws, I need not reach the issue of whether Blue Cross would have a valid state action defense and make no decision thereon.

addition, the Superintendent of Insurance must (1) approve Blue Cross' subscriber contracts for hospital or medical coverage, N.Y.Ins.L. § 4308(a), (2) approve Blue Cross' subscriber premiums or the rating formula from which premiums are determined, N.Y.Ins.L. § 4308(b), and (3) hold a public hearing on any proposed community rate increases for hospital and medical coverage, N.Y.Ins.L. § 4308(c). *See*, Corcoran Aff. at ¶¶ 5-7. The state's supervision suggests that novel judicial applications of antitrust law are unlikely to be required to prevent Blue Cross from abusing its market power.

Third, to the extent that consumer welfare is the goal of antitrust,[17] a court should be hesitant to extend antitrust law to strike down a system that currently saves consumers about $25 million a year in radiology fees.[18]

Thus, Blue Cross has not violated Section 1 of the Sherman Act as alleged in the Radiologists' first claim for relief. The Radiologists' First Claim for Relief is hereby dismissed.

2. *Sherman Act § 2*

[2] The Radiologists also contend that Blue Cross' agreements with hospitals constitute monopolization or attempts to monopolize in violation of § 2 of the Sherman Act. For purposes of this motion, the Court will assume that Blue Cross has significant market power as a purchaser of hospital benefits and services.[19] The Radiologists argue that Blue Cross' use of its

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[17] *See NCAA v. Board of Regents*, 468 U.S. at 107, 104 S.Ct. 2963; *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343, 99 S.Ct. 2326, 2333, 60 L.Ed.2d 931 (1979); *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 486 n. 10, 97 S.Ct. 690, 696 n. 10, 50 L.Ed.2d 701 (1977); R. Bork, *The Antitrust Paradox* 7-9 (1978).

[18] "The real danger for the law is less that predation will be missed than that normal competitive behavior will be wrongly classified as predatory and suppressed." Bork, *supra*, at 157.

[19] The Court notes the difficulty in determining Blue Cross' market share. Blue Cross calculates its market share by determining the percentage of hospitals' net

(*Footnote continued*)

market power to extract favorable prices from hospitals has the purpose and effect of (1) injuring Blue *Cross*' competitors (other group purchasers of hospital services and benefits), and (2) injuring Blue *Shield*'s competitors (other group purchasers of medical services).

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inpatient revenues attributable to Blue Cross; Blue Cross estimates its market share to be just over 20% using this calculation. Affidavit of Jerry Weissman, July 27, 1988, ¶ 40. Blue Cross bases its estimate on State Department of Health Reports, which it concedes include hospital revenues from all payors, including donations and payments from governments. Tr. at 46. The Radiologists counter with the deposition testimony of a few hospital administrators who estimate the percentage of their hospitals' total revenues attributable to Blue Cross to be approximately 30%. However, this figure represents Blue Cross' economic power in only a small percentage of the hospitals involved. The Radiologists deposed approximately six hospital administrators, only some of whom were asked about the percentage of funds attributable to Blue Cross; there are more than sixty hospitals in the Downstate area.

The Radiologists agree that the percentage of hospital revenues is the appropriate measure of Blue Cross' economic power over the *hospitals*, but argue that the appropriate measure of Blue Cross' market power vis-a-vis its competitors is the percentage of persons in the Downstate region who are covered by Blue Cross, *or* the percentage of persons in the Downstate region with medical coverage who are covered by Blue Cross. Tr. at 50-52. Using this calculation, the Radiologists estimate Blue Cross' market share at 80% to 90%. However, as Blue Cross pointed out at oral argument, "double counting" is in part responsible for its high market share. Many consumers are covered by more than one hospital insurance policy. Tr. at 56-57, 64. For example, some consumers may purchase 60-day Blue Cross hospital coverage, and supplemental coverage from another company. The Radiologists have counted anyone who has *some* Blue Cross coverage as a Blue Cross subscriber. The parties have not produced the information regarding Blue Cross' competitors' coverage that would be required to eliminate this double-counting (indeed, the information may be unavailable to them).

In addition, the parties disagree as to the inclusion of "uninsurables" in the number of persons covered by Blue Cross; there is no competition for these community rated subscribers. Blue Cross estimates that 45% of its subscribers are community rated subscribers.

The parties also disagree on the propriety of including Medicare funds in the calculation of Blue Cross' market share. Tr. at 46-47. Part A of Medicare provides hospital insurance coverage for individuals who qualify for monthly

(*Footnote continued*)

a. Injury to Blue Cross' Competitors

Even assuming that Blue Cross uses its market power to obtain favorable prices from hospitals, Blue Cross has not thereby violated Section 2 of the Sherman Act. The law does not prevent a buyer with market power from negotiating a good price, or from specifying what it will buy. "Antitrust law rarely stops the buyer of a service from trying to determine the price or characteristics of the product that will be sold." *Kartell*, 749 F.2d at 925. "Even if the buyer has monopoly power, an antitrust court . . . will not interfere with a buyer's (nonpredatory) determination of price. . . . A legitimate buyer is entitled to use its market power to keep prices down." *Id.* at 929; *see*, *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 297 (2d Cir. 1979), *cert. denied*, 444 U.S. 1093, 100 S.Ct. 1061, 62 L.Ed.2d 783 (1980) (analogous conclusion with respect to *sellers* with market power). There is no evidence that Blue Cross has interfered in any way

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Social Security benefits as well as for certain disabled persons. 42 U.S.C.A. § 1395c. Pursuant to 42 U.S.C. § 1395cc(a)(1)(A), Part A providers agree not to charge individuals covered by Medicare for the inpatient services rendered to them. Instead the providers accept reimbursement from the trust fund, in amounts calculated under Medicare regulations by the Health Care Financing Administration or, at the option of the provider, by private organizations under contract with HCFA. These private parties (fiscal intermediaries) act as agents of HHS in administering the Medicare Program.

Blue Cross is an approved Medicare fiscal intermediary. It is therefore responsible for the payment of substantial sums of Medicare funds to the hospitals. However, as a fiscal intermediary, Blue Cross serves only as a "conduit," and cannot resolve policy questions. *Heckler v. Community Health Services*, 467 U.S. 51, 64-65, 104 S.Ct. 2218, 2225-2226, 81 L.Ed.2d 42 (1984). The Radiologists point out, however, that since Blue Cross is the conduit for these funds, Blue Cross can control the timing of Medicare payments to hospitals. Tr. at 53. On the other hand, no hospital is required to select Blue Cross as its fiscal intermediary; at least sixteen hospitals in the Downstate New York area have chosen an approved fiscal intermediary other than Blue Cross.

Finally, the Court notes that it has been suggested that health insurers' bargaining power may not be as great as their size suggests, because pressure from their individual subscribers would prevent them from, *e.g.*, disallowing reimbursement at 90% of the hospitals in an area. "Joint Provider Activities Affecting Price," *supra*, at 74 n. 218.

with any competitor's ability to obtain similar terms from sellers. See p. 713 *ante*. In these circumstances, the Radiologists have presented no evidence that Blue Cross' use of its market power to extract low prices was unlawful.[20]

b. Injury to Blue Shield's Competitors

The Radiologists claim that one of the reasons Blue Cross insists on purchasing radiology services from hospitals is that it wants to use its leverage in one market (the hospital service and benefit insurance market) to gain a competitive advantage in a second market (the medical service insurance market), where its affiliate Blue Shield is weak. For purposes of this decision, the Court will assume that Blue Shield is less successful than Blue Cross.

The Radiologists have offered no evidence that Blue Cross' purpose in insisting on purchasing radiology services for its subscribers is to assist its weaker affiliate Blue Shield, and several facts make this argument implausible. There is no dispute that when a hospital patient has Blue Cross coverage, Blue Cross is always billed for the hospital radiology fees, and those fees are never billed to anyone else (whether the patients subscribe to Blue Shield or to a competitor of Blue Shield). Thus, Blue Shield's competitors benefit from Blue Cross' policy as much as does Blue Shield — none of them pays for radiology services for patients with Blue Cross coverage. Tr. at 33-34.

Second, there is no evidence indicating that (and it is illogical to assume that) consumers would select Blue Shield over a competing insurer because of some differential in premium costs that

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[20] The Radiologists point to a remark by Mr. Lovett of Blue Cross, to the effect that direct billing by radiologists would imperil Blue Cross' market share (presumably by making Blue Cross coverage less valuable). Minutes of Meeting of Hospital Review Committee of Blue Cross and Blue Shield of Greater New York, April 4, 1984, at 4. Whether or not Mr. Lovett is correct, this statement alone is not probative of any unlawful conduct on the part of Blue Cross. Even if this remark showed an intention on Mr. Lovett's or Blue Cross' part to limit competition, ". . . an admitted intention to limit competition will not make illegal conduct that we know to be pro-competitive or otherwise immune from antitrust control." 7 Areeda, *supra* ¶ 1506 at 391.

might result from the fact that Blue Shield does not offer to pay its subscribers' in-hospital radiology bills. Since no medical insurer pays in-hospital radiology bills for Blue Cross subscribers, every medical insurer, not just Blue Shield, can offer two plans: one plan for non-Blue Cross subscribers, that pays in-hospital radiology bills, and a cheaper plan, for Blue Cross subscribers, that does not. The Radiologists admit that in reality Blue Shield's competitors do just that. Tr. at 32. Blue Shield gains nothing vis-a-vis its competitors by the inclusion of in-hospital radiology services in Blue Cross hospital benefits. There is thus no injury to competition in the medical service insurance market. In addition, because it is so unlikely, if not impossible, that Blue Cross' decision to purchase radiology services could injure competition in the medical service insurance market, it is highly improbable that Blue Cross' purpose in purchasing such services is to benefit Blue Shield.[21]

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[21] Faced with the reality that Blue Shield gets no cost advantage from Blue Cross' purchase of radiology services, the Radiologists attempted to reformulate their theory of injury (this new theory was raised for the first time at oral argument on this motion, more than three and one-half years after this litigation began). They now argue that Blue Shield is a less efficient claims handler than its competitors, and that Blue Cross, by shielding Blue Shield from the need to process the Radiologists' bills, harms Blue Shield's competitors by making radiology bills "one area [in] which they do not get to demonstrate their competitive advantage, the better administration . . ." Tr. at 34. Thus, the Radiologists argue, Blue Shield gains a competitive advantage by having "one less area to screw up in." *Id.* In addition, while acknowledging that all medical insurers benefit from Blue Cross' purchase of radiology services, the Radiologists argue that if medical insurers had to pay radiology bills, the additional burden would be more costly for Blue Shield than for its competitors because Blue Shield is less efficient than its competitors; Blue Shield would then have to increase its premiums by a greater amount than would its competitors.

The Radiologists have offered no evidence that Blue Shield is less efficient than its competitors. After oral argument, the Radiologists submitted three documents purporting to demonstrate Blue Shield's inefficiency. Plaintiff's Post-Argument Affidavit, Exs. D, E, and F. Although these documents reflect some consumer dissatisfaction with *both Blue Cross and Blue Shield* (eg.: "Both carriers draw particularly heavy criticism on the time required to process claims, . . ." Plaintiff's Post-Argument Affidavit, Ex. E at VII), none of these documents

(*Footnote continued*)

In addition, Blue Cross had a policy of purchasing in-hospital radiology services long before Empire acquired Blue Shield in 1978. Thus, Blue Cross' *purpose* in *adopting* this policy could not have been to give Blue Shield an edge over Blue Shield's competitors.[22]

Thus, even assuming that Blue Cross has significant market power, Blue Cross has not violated Section 2 of the Sherman Act as alleged in the Radiologists' second and third claims for relief; accordingly, the Radiologists' Second and Third Claims for Relief are hereby dismissed.

## CONCLUSION

Because I hold that the plaintiffs are not entitled to antitrust relief, I need not reach defendant's McCarran-Ferguson and state action defenses or plaintiffs' cross-motion for partial summary judgment with respect to those defenses. The state law claim must be dismissed for lack of pendent jurisdiction.

Accordingly, defendant's motion for summary judgment is hereby granted; this action is hereby dismissed with prejudice.

SO ORDERED.

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contains any data concerning Blue Shield's costs or efficiency in comparison to Blue Shield's competitors. Any argument based on an assumption that Blue Shield would be inefficient in handling radiology claims as compared to Blue Shield's competitors is pure speculation and unsupported by evidence.

In addition, as with the Radiologists' original leveraging claim, there is no evidence that Blue Cross purchases radiology services for the purpose of denying Blue Shield this opportunity to fail.

[22] Even if Blue Cross decided in 1978 to *persist* in its long-standing policy, for the purpose of injuring Blue Shield's competitors, its persistence is not paying off. The number of Blue Shield subscribers has declined every year save one since its consolidation with Blue Cross. Defendant's Memorandum of Law in Support of Motion for Summary Judgment, p. 48. Its market share has declined as well. Even the Radiologists' counsel estimates that Blue Shield's market share in the medical service insurance market has fallen from 50% to 30% in the past five or ten years. Tr. at 32.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

| | | |
|---|---|---|
| WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al., | : | |
| Plaintiffs, | : | 85 Civ. 2733 (SWK) |
| — against — | : | ORDER |
| EMPIRE BLUE CROSS AND BLUE SHIELD, INC., | : | |
| Defendant. | : | |

Westchester Radiological Associates, P.C., *et al.* having commenced this action against Empire Blue Cross Blue Shield ("Empire") seeking damages and injunctive relief;

Empire having filed a motion to dismiss the action against it on the grounds that (1) the operation of the contracts between Empire and its member hospitals, as alleged in the complaint, do not constitute violations of the Sherman Act, (2) plaintiffs lack standing to challenge certain of the violations of the Sherman Act alleged in the complaint, and (3) accordingly, the Court lacks jurisdiction over the plaintiffs' pendent state law claims;

the court having denied that motion in its Memorandum Opinion and Order filed April 27, 1987, and Empire having requested that the Court reconsider its Memorandum Opinion and Order or, in the alternative, certify it for interlocutory appeal pursuant to 28 U.S.C. § 1292(b); and

the Court having considered the submissions of all parties, having declined to reconsider its Memorandum Opinion and Order and having found that said order involved controlling

questions of law as to which there is substantial ground for difference of opinion and that an immediate appeal would materially advance the ultimate termination of the litigation;

NOW, THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED AS FOLLOWS:

The Memorandum Opinion and Order filed April 27, 1987, which denied Empire's motion to dismiss the complaint in its entirety is hereby certified for interlocutory appeal pursuant to 28 U.S.C. § 1292(b).

SO ORDERED.

SHIRLEY WOHL KRAM
UNITED STATES DISTRICT JUDGE

Dated: New York, New York
June , 1987

WESTCHESTER RADIOLOGICAL ASSOCIATES, P.C., et al., Plaintiffs,

v.

EMPIRE BLUE CROSS AND BLUE SHIELD, INC., Defendant.

No. 85 Civ. 2733 (SWK).

United States District Court, S.D. New York

April 23, 1987.

Hospital-based radiologists brought action against nonprofit health insurance corporation organized under New York insurance law alleging unlawful restraint of trade, monopolization, and price fixing in violation of federal antitrust laws, as well as New York State law, on ground that corporation insisted that both technical component and professional component of radiological services provided to subscribers be treated as covered hospital service rather than as services provided by physician. Defendant moved to dismiss the complaint. The District Court, Kram, J., held that: (1) proposition that buyers and sellers may negotiate about terms of purchase without violating antitrust laws did not apply where buyer, a nonprofit health insurance corporation organized under New York insurance law had no contractual relations with the sellers, the hospital-based radiologists, and (2) radiologists had standing to pursue claims.

Motion denied.

MEMORANDUM OPINION AND ORDER

KRAM, District Judge.

This is an action under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, and the Donnelly Act, N.Y.Gen.Bus.Corp.Law § 340. Plaintiffs allege unlawful restraint of trade, monopolization, and price fixing in violation of the federal antitrust laws as well as New York State law. Plaintiffs seek injunctive and treble damage relief. The case is presently before the court on defendant's motion to dismiss the complaint, pursuant to Rule 12(b)

of the Federal Rules of Civil Procedure, on the grounds: (1) that plaintiffs' claim under Section 1 of the Sherman Act fails to state a claim under the antitrust laws upon which relief can be granted; (2) that plaintiffs lack standing to maintain an action based on their claims under Section 2 of the Sherman Act; and (3) that, as a result, this Court lacks jurisdiction to consider plaintiffs' pendent state law claim. For the reasons set forth below, defendant's motion is denied.

## FACTS

The basic facts are not in dispute. Plaintiffs are a majority of the hospital-based radiologists (the "Radiologists") who work in the seventeen counties in and around New York City ("Downstate New York"). Defendant Empire Blue Cross and Blue Shield, Inc. ("Empire") is a non-profit health insurance corporation organized and existing under Article 43 of the New York Insurance Law. Empire is the product of a merger of Blue Cross/Blue Shield of Greater New York, Inc., which served Downstate New York, and Blue Cross of Northeastern New York, Inc., which served the Northeastern New York area.

Empire offers two basic insurance plans: (1) "Blue Cross," which covers certain defined hospital benefits, and (2) "Blue Shield," which covers professional medical services provided by physicians. Empire provides Blue Cross hospital service benefit coverage to more than 9 million covered persons. In order to provide inpatient hospital services under these subscriber contracts, Empire has contracts with hospitals whereby the hospitals accept state regulated payments from Empire as full reimbursement for such services and may not seek to collect additional charges from Empire's subscribers. Empire does not pay on the basis of the particular hospital services that may be rendered to a particular patient; instead, Empire makes a "per diem" payment calculated on the basis of the hospital's overall expenses as incurred in a previous "base" year.

Empire's Blue Shield plan, on the other hand, covers bills for physicians' services actually rendered to a patient, whether in

the hospital, the examining room or the home. "Participating" physicians send their bills to Empire, and Empire pays the physician an agreed-upon amount for the services rendered. "Non-participating" physicians send their bills directly to a subscriber, who, in turn, is reimbursed by Empire in the same amount it would have paid had the physician been a participant. Subscribers are then left to pay any difference in cost. In either case, the physician bills for specific services as performed, and the size of his fee depends on the nature of those services.

Radiologists are licensed physicians who have completed special residency programs in radiology[1] and have thereby become qualified in that particular medical specialty. The Radiologists, pursuant to agreements which they have maintained with various hospitals in Downstate New York, practice on hospital premises, as opposed to in private offices.

In general, health insurance plans allow hospital-based radiologists to direct-bill their patients — or their patients' medical insurance carriers — for diagnostic — but not technical — radiological services actually rendered by a radiologist in a hospital. In Downstate New York, however, the hospital-based Radiologists receive compensation for their services directly from the hospitals. Such compensation is included as a cost in the computation of the Blue Shield per diem reimbursement rate paid by Empire to these hospitals.

According to the Radiologists' complaint, Empire alone insists that both the technical component and the professional component of radiological services provided to Blue Cross subscribers be treated as a covered hospital service under its Blue Cross plan, and, as a result, the Radiologists are compelled to accept reimbursement from the hospitals for services provided subscribers at levels substantially lower than would have prevailed in the absence of Empire's unlawful acts and in freely competitive

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[1] The Second Amended Complaint defines "radiology" as "the medical specialty concerned with the diagnostic and therapeutic use of x-rays, radium rays and other forms of radiant energy or its equivalent, in the diagnosis and treatment of disease or injury."

conditions. In other words, if Empire would agree to let radiologists bill directly for the professional/diagnostic component of their services – as all other physicians allegedly are allowed to do – they could make more money. Indeed, the Radiologists specifically claim that the clear and intended effect of Empire's policy[2] is to reduce hospital-based radiologists' income in Downstate New York by some $25 million per year so as to preserve the attractiveness of its Blue Cross coverage as against its hospital insurance competitors and avoid saddling the Blue Cross plan with the need to raise its premiums and lose business to its competitors.

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[2] Empire explains that:

> In 1969, however, the New York Legislature became convinced that retrospective reimbursement failed to encourage the hospitals to control their costs, which were increasing at an alarming rate. As a result, the Legislature revised Chapter 28 of the Public Health Law, which set forth the procedure for determining hospital reimbursement, and directed the Commissioner of Health to develop an "effective cost control program" that would "both enable and motivate hospitals to control their spiraling costs" (Chapter 957, 1969 N.Y. laws). Given this mandate, the Commissioner developed regulations, now codified as NYCRR § 86-1.1, *et seq.* (the "Regulations" or "Part 86"), that established the system of "prospective" reimbursement that remains in use in New York State.
>
> Instead of paying the hospital for the charges for all items of care rendered to each individual patient, under a prospective methodology Blue Cross pays a set amount to the hospital for each "patient day" of care rendered to a person with Blue Cross hospital coverage. That amount, referred to as the "*per diem* reimbursement rate" in paragraph 12 of the Complaint, is established annually for each Downstate Hospital on the basis of financial data it supplies and is provided to each hospital in advance of the rate year so that each may have an opportunity to plan its budget accordingly. If, during the rate year, a hospital's cost of providing care is less than the *per diem*, the hospital retains the difference. If the cost of care is greater than the payment rate, the hospital absorbs the difference. Thus, prospective reimbursement gives the hospitals an incentive to reduce waste and to make their own operations more efficient.

As a result, the Radiologists allege (1) that Empire has, in combination and concert with the hospitals in Downstate New York, fixed prices and otherwise restrained the manner in which the Radiologists bill for their time in violation of Section One of the Sherman Act, (2) that injury to the Radiologists is the precisely intended consequence of, and is inextricably intertwined with Empire's attempted monopolization of the hospital insurance market and its leveraging of that monopoly into an anticompetitive advantage in the medical insurance market in violation of Section 2 of the Sherman Act, and (3) that, as a result, Empire also has violated New York State antitrust law.

## DISCUSSION

Empire, accepting the factual allegations in the complaint as true for the purposes of its motion, moves to dismiss on three grounds. First, Empire argues that the complaint fails to state an antitrust claim because Empire's contracts with the hospitals are merely arrangements for the purchase of goods and services by Empire and antitrust law usually permits a legitimate buyer to use its market power to keep prices down. Second, Empire contends that, because the Radiologists are neither consumers nor competitors in the relevant market, they lack standing to pursue an action for abuse of monopoly power in that market. Third, Empire argues that jurisdiction over the New York State Donnelly Act claim is pendent to the federal antitrust claims and must fail for want of federal jurisdiction once the Radiologists' federal claims have been dismissed.

### *The Section One Claim*

Section 1 of the Sherman Act provides in relevant part that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations is declared to be illegal." 15 U.S.C. § 1. In relation to the health insurance field, the weight of authority holds that a contract that sets the price for services between a buyer—such as Empire—and a seller—such as a hospital, a physician, a psychotherapist or a pharmacy—is neither per se illegal nor an unreasonable restraint

of trade under Section 1. *E.g.*, *Brillhart v. Mutual Medical Insurance, Inc.*, 768 F.2d 196 (7th Cir. 1985); *Kartell v. Blue Shield of Massachusetts, Inc.*, 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029, 105 S.Ct. 2040, 85 L.Ed.2d 322 (1985); *Royal Drug Co. v. Group Life & Health Insurance Co.*, 737 F.2d 1433 (5th Cir.1984), *cert. denied*, 469 U.S. 1160, 105 S.Ct. 912, 83 L.Ed.2d 925 (1985); *Klamath-Lake Pharmaceutical Association v. Klamath Medical Service Bureau*, 701 F.2d 1276 (9th Cir.1983), *cert. denied*, 464 U.S. 822, 104 S.Ct. 88, 78 L.Ed.2d 96 (1983); *Medical Arts Pharmacy of Stamford, Inc. v. Blue Cross & Blue Shield of Connecticut, Inc.*, 675 F.2d 502 (2d Cir.1982) (per curiam); *Webster County Memorial Hospital, Inc. v. United Mine Workers of America Welfare & Retirement Fund of 1950*, 536 F.2d 419 (D.C.Cir. 1976) (per curiam); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.*, 603 F.Supp. 1077 (S.D.Ind.1985), *aff'd*, 784 F.2d 1325 (7th Cir.1986); *Sausalito Pharmacy, Inc. v. Blue Shield*, 544 F.Supp. 230, *aff'd per curiam*, 677 F.2d 47 (9th Cir.), *cert. denied*, 459 U.S. 1016, 103 S.Ct. 376, 74 L.Ed.2d 510 (1982); *Michigan State Podiatry Association v. Blue Cross and Blue Shield of Michigan*, 1982-2 Trade Cas. (CCH) ¶ 64,801 (E.D.Mich.1982); *Blue Cross and Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics*, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D.Mich.1980).

Relying on the *Kartell* line of cases, Empire argues that the Radiologists' Section One claim should be dismissed on the grounds that:

> In essence, then, the lawfulness of the term in question stems from the fact that it is an essential part of the price bargain between the buyer and seller. Whether or not that price bargain is, in fact, reasonable is, legally speaking, beside the point, even in the case of a monopolist. As Blue Shield stresses in its brief, health maintenance organizations, independent practice associations and preferred provider organizations all routinely agree with doctors that the doctors will accept payment in full for services rendered to its subscribers. We can find no relevant

> analytical distinction between this type of purchasing decision and the practice before us — even on the assumption that Blue Shield possesses market power.

*Kartell*, 749 F.2d at 928-29. As a result, Empire contends that it can legally hold to its longstanding arrangements with the hospitals to the effect that radiological services for persons it covers are the responsibility of the hospitals to provide and purchase.

[1] The Radiologists, however, rightly contend that the *Kartell* line of cases, which stands for the proposition that buyers and sellers may negotiate about the terms of purchase without violating the antitrust laws, is inapposite here where the buyer (Empire) has no contractual relations with the sellers (the Radiologists) and has not negotiated for any. Rather, the crucial agreement here, whereby Empire allegedly compels the hospitals to prevent the direct billing of Blue Cross subscribers for the Radiologists' diagnostic services, is between Empire and the hospitals, *not* Empire and the Radiologists. This triangular relation — with Empire intervening as a third force — is expressly excluded from the holding in the *Kartell* line of cases:

> To find an unlawful restraint, one would have to look at [Empire] as if it were a "third force," intervening in the marketplace in a manner that prevents willing buyers and sellers from independently coming together to strike price/quality bargains.

*Kartell*, 749 F.2d at 924.

In other words, although buyers may permissibly bargain with sellers, if the insurance plan in *Kartell* had not dealt bilaterally with the physician-sellers of medical services but instead had acted as an inhibitory "third force" interfering in a separate buyer/seller relationship involving other persons, the relationship would not have been exempt from antitrust scrutiny. That, of course, is precisely the present case; Empire here is charged with intervening in the relationship between the Radiologists and the hospitals so as to prevent hospital-based radiologists from direct billing their patients for professional medical services.

Accordingly, Empire's motion to dismiss the Radiologists' Section One claim on the ground that the Kartell line of cases is dispositive of that claim is denied.

*The Section Two Claims*

With respect to claims under Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2, courts have grafted a doctrine of standing onto the sweeping language of Section 4 of the Clayton Act, 15 U.S.C. § 15. *Crimpers Promotions Inc. v. Home Box Office, Inc.*, 554 F.Supp. 838, 842 (S.D.N.Y. 1982), *aff'd*, 724 F.2d 290 (1983). Section 4 of the Clayton Act permits "[a]ny person who shall be injured in his business or property by reason of anything forbidden in the antitrust laws" to sue for treble damages recovery in federal district court. 15 U.S.C. § 15.

The Supreme Court most recently addressed questions of antitrust standing in *Blue Shield of Virginia v. McCready*, 457 U.S. 465, 102 S.Ct. 2540, 73 L.Ed.2d 149 (1982), and *Associated General Contractors of California, Inc. v. California State Council of Carpenters*, 459 U.S. 519, 103 S.Ct. 897, 74 L.Ed.2d 723 (1983). In *McCready*, the Supreme Court acknowledged two types of limitations on the availability of the Section 4 remedy to particular classes of persons and for redress of particular forms of injury: (1) limitations designed to prevent double recovery, and (2) limitations where the injuries are "too remote" from the antitrust violation to afford standing. *McCready*, 457 U.S. at 472-78, 102 S.Ct. at 2544-47. In *Associated General*, the Supreme Court found certain other factors also to be relevant to the question of antitrust standing: (1) whether the alleged injury resulted from anaticompetitive activity, i.e., was of the type sought to be prevented by the antitrust laws, (2) whether the asserted injury was direct or indirect, (3) whether there existed an alternative plaintiff "whose self-interest would normally motivate them to vindicate the public interest in antitrust enforcement," (4) whether the nature of the damages was speculative, and (5) whether there was danger of double recovery. *Associated General*, 459 U.S. at 535-44, 103 S.Ct. at 907-11. *See also Donahue v. Pendleton Woolen Mills, Inc.*, 633 F.Supp. 1423,

1432 (S.D.N.Y.1986); *Rosenberg v. Gottlieb, Steen & Hamilton*, 598 F.Supp. 642, 644-45 (S.D.N.Y.1984).

*Associated General* also advises federal courts to abstain from black letter rules and to analyze the facts in each case. *Id.*, 459 U.S. at 536 n. 33, 103 S.Ct. at 907 n. 33; *Crimpers Promotions, Inc. v. Home Box Office, Inc.*, 724 F.2d 290, 293 (2d Cir.1983). In light of this admonition, the Second Circuit, which previously had followed the "target area" approach to such determinations, provided that:

> While we do not hold that *Calderone [Enterprises Corp. v. United Artists Theatre Circuit, Inc.*, 454 F.2d 1292 (2d Cir.1971), *cert. denied*, 406 U.S. 930, 92 S.Ct. 1776, 32 L.Ed.2d 132 (1972),] and *Billy Baxter [, Inc. v. Coca-Cola Co.*, 431 F.2d 183 (2nd Cir.1970), *cert. denied*, 401 U.S. 923, 91 S.Ct. 877, 27 L.Ed.2d 826 (1971),] have been drained of their precedential vitality on their own or very similar facts, we think that in approaching new problems, courts of this circuit would do better, indeed are compelled, to follow the approaches adumbrated by the Supreme Court in *McCready* and *Associated General* without concern whether the results are consistent with language in earlier Second Circuit cases.

*Crimpers Promotions*, 724 F.2d at 293.

Empire contends here that the Radiologists monopoly claims under Section 2 must be dismissed as the Radiologists lack standing to challenge Empire's alleged monopolization of the hospital insurance market and its monopoly leveraging of the medical insurance market. Specifically, Empire argues that the Radiologists are neither consumers nor competitors in the hospital insurance market and that there is an identifiable class of persons—namely the private competing health insurance companies—whose self-interest normally would motivate them to vindicate the public interest and bring such an action. As

a result, Empire contends that, pursuant to *Associated General*, the Radiologists lack standing to commence this antitrust action.

[2, 3] Empire's arguments are unavailing. An antitrust plaintiff need not be either a competitor or a consumer in the relevant market in order to have antitrust standing. *McCready*, 457 U.S. at 483-84 & n. 21, 102 S.Ct. at 2250-51 & n. 21; *Crimpers Promotions*, 724 F.2d at 296 n. 6. Furthermore, the Court has analyzed the *McCready* limitations and the *Associated General* factors relative to this case and determines that the Radiologists do indeed have standing to pursue their Section 2 claims.

There is no potential here for double recovery by the Radiologists as their losses are readily separable from any competitive disadvantage suffered by another insurer. Nor are their alleged injuries too remote from the alleged antitrust violations to afford standing; indeed, their alleged injuries are the "precisely intended consequence" of Empire's alleged antitrust violations and are "inextricably intertwined" with the advantages Empire allegedly seeks to gain against its competitors. *Crimpers Promotions*, 724 F.2d at 294-95. As a result, the *McCready* limitations are not a bar to standing here.

The Radiologists also succeed under the factors enunciated in *Associated General*. First, the alleged injury results from Empire's alleged anticompetitive conduct. Second, the Radiologists alleged injury is directly related to Empire's alleged anticompetitive benefit and is specifically directed against the Radiologists. Third, because the Radiologists allegedly are the targets of Empire's conduct, they are the logical plaintiffs to bring this action. In addition, the impact of Empire's alleged conduct on the competing insurers, which are other potential plaintiffs identified by Empire, may indeed not be sufficiently injurious to the competing insurers for them to undertake the time and expense of litigation. Fourth, the Radiologists' damages appear readily calculable in that the Radiologists' records will reflect what services they performed for Blue Cross subscribers and what the comparable billings for those services should have

been based on direct billings under other health insurance policies. Fifth, there is no risk of duplicate recovery.

In sum, the Radiologists satisfy the antitrust standing requirements of both *McCready* and *Associated General*, and are clearly appropriate plaintiffs in this antitrust action. Accordingly, Empire's motion to dismiss the Radiologists' Section 2 claims for lack of standing is denied.

*The Donnelly Act Claim*

[4] Jurisdiction over Donnelly Act claims is pendent to, and thus derives from, the federal antitrust claims. Because Empire's motion to dismiss the federal claims is denied, the Court also maintains federal jurisdiction over the Radiologists' Donnelly Act claim.

## CONCLUSIONS

Accordingly, for the reasons outlined above, Empire's motion to dismiss the complaint pursuant to Rule 12(b) of the federal Rules of Civil Procedure is denied in its entirety.

SO ORDERED.